KAISER PERMANENTE®

Non-Contracted Provider Request for Authorization

**** The preferred method for referral requests is the Referral Request application at https://identity.onehealthport.com/EmpowerIDWebIdPForms/Login/KAISER_WA_PROD ****

You may contact Kaiser Permanente Review Services department at 1-800-289-1363.

Routine requests will be processed within 5 days unless more information is required. If more information is needed, we will contact you at the number you provide below.

To submit this request as Urgent sign the following attestation:

I attest this request is URGENT because delaying this referral could seriously jeopardize the life or health, the ability to regain maximum function, or lead to ongoing severe pain for the patient. I understand Urgent referrals often require processing within 1 calendar day." Name_____ Date: _____

***All fields are required – missing information will delay your request**

*Requestor's Name:	*Requestor's Phone: *Requestor's Fax:	
Kaiser Permanente Washington – Member Information		
*Member Name:	*Kaiser Permanente Washington Member ID #:	*Member Date of Birth:
Referring Provider Information		
*Referring Physician's name and NPI:	*Referring Clinic name and address:	
*Referring Physician's specialty:	*Referring Clinic Phone *(if different from requestor):*	
*Referring Clinic Tax ID:	*Referring Clinic Fax *(if different from requestor)*:	
Referred To Provider Information		
*Name of Referred To Physician:	*Address of Referred To Clinic/Organization:	
*Name of Referred To Clinic/Organization:		
*Tax ID # or NPI of Referred To Clinic/Organization:	*Phone Number of Clinic/Organization:	

*Specialty of Referred To Physician/Organization:	*Fax Number of Referred To Clinic/Organization:
*Facility or Hospital Name & Address (if applicable):	*Facility Phone and Fax Number:
Diagnosis/Procedure Information	
***ICD-10** Diagnosis Code/Description (up to 2):	*Procedure or Equipment Code/Description (**CPT/HCPCS**):

*Place of Service:

◯ Office ◯ ASC ◯ Hospital Outpatient ◯ Inpatient Facility ◯ Home

◯ ESRD Dialysis Facility ◯ Other _____

Notes:

◯ Check here to indicate that clinical information/medical records are attached

When all required fields are completed, please print, and fax this form to

Kaiser Permanente Review Services at 1-888-282-2685